

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001143	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER PORTAGE MANOR HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3016 PORTAGE AVE SOUTH BEND, IN 46628		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00187529 and IN00189494.</p> <p>Complaint IN00187529 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00189494 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: December 29 - 30, 2015</p> <p>Facility number: 001143 Provider number: 001143 AIM number: N/A</p> <p>Residential Census: 126</p> <p>Sample: 3</p> <p>Portage Manor Health Care Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00187529 and IN00189494.</p> <p>Quality Review completed by 14454 on January 6, 2016.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE